



**A STRATEGY PAPER ON FAMILY WELFARE  
(REPRODUCTIVE AND CHILD HEALTH INCLUDING IMMUNISATION  
AND FAMILY PLANNING)**

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<b>Annex No.</b>	<b>Contents</b>
I	KEY RCH INDICATORS, KEY STRATEGIES, ISSUES & WAY FORWARD
II	EXISTING VISION, MISSION, OBJECTIVES AND FUNCTIONS OF THE DEPARTMENT OF HEALTH AND FAMILY WELFARE
III	IDENTIFICATION AND STRENGTHENING OF MCH CENTRES

<sup>i</sup> The contents are arranged as outlined in the preliminary draft of "How to Prepare Strategy and Strategic Plans: Guidelines and Checklist for Practitioners"; Performance Management, Cabinet Secretariat, January 2010

# **A STRATEGY PAPER ON FAMILY WELFARE (REPRODUCTIVE AND CHILD HEALTH INCLUDING IMMUNIZATION AND FAMILY PLANNING)**

## **EXECUTIVE SUMMARY**

Nearly 65,000<sup>1</sup> women die annually in India as a consequence of pregnancy and childbirth, and 17 lakh<sup>2</sup> children die before reaching the age of 5 years. Most of these deaths are preventable<sup>3,4</sup>. Not surprisingly, the 12<sup>th</sup> Plan identifies better preventive and curative healthcare, particularly for women and children, as a key challenge.

The strategy paper while recognising the need for enhanced public investment in reproductive and child health (RCH), including immunisation and family planning, seeks to lay greater emphasis on **more efficient use of public resources and attainment of outcomes as reflected in improved health indices**. The context is provided by emerging concerns about uneven and slow progress on key goals relating to Maternal Mortality Ratio (MMR), Infant Mortality Rate (IMR), and Total Fertility Rate (TFR) notwithstanding augmented funding to States under the National Rural Health Mission (NRHM) to the tune of nearly Rs 55,000 crores during the period 2005-06 to 2010-11.

The paper proposes an innovative and more significantly, a practical strategic framework to bring about result- oriented performance with regard to reproductive and child health. It sets out an **overarching “systems thinking” approach**, as espoused by Peter Senge<sup>5</sup>, aimed at discovering the snake beneath the carpet rather than struggling to fix the bumps on the surface of the carpet, and seeing the “whole” in the long run rather than just the parts in the short run. The framework identifies highly inter related **25 management imperatives** critical for seamless service delivery. It can be argued that absence of any of these would threaten to unhinge the system, impinge on composite quality of public health services, impede progress on goals and push up costs in the long run.

Embedded in the “systems thinking” approach and the 25 management imperatives is the imperative to avert disease, morbidity and mortality through renewed focus on public health with a focus on social determinants of health, e.g. half of India’s malnutrition is

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<sup>1</sup> SRS 2004-6

<sup>2</sup> World Health Statistics, 2007

<sup>3</sup> Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights, 2010

<sup>4</sup> UNICEF, The State of the World’s Children 2009: Maternal and Newborn Health (United Nations publication, Sales No. E.09.XX.1)

<sup>5</sup> Peter M. Senge: The Fifth Discipline - The Art and Practice of the Learning Organization, 1990

estimated to be caused by infections arising from poor sanitation<sup>6</sup>. The imperative assumes significance as an overwhelming reliance on curative medical services may lead to high costs and tardy progress in the long run.

The human resources (HR) imperative can easily be termed as the most given its profound impact on service delivery and the weakness of the existing HR policies and systems in states. Thus an **accountability framework** has been proposed under which roles and responsibilities of key service providers viz. doctors, nurses, ANMs are clarified, minimum output expectations spelt out, information on performance regularly appraised and incentives/ disincentives for performance above/ below benchmarks enforced. A new concept of result based financing for public health facilities is also a part of the accountability framework.

At the heart of the systems approach lies a road map on bringing community and clients centerstage. Building bridges and partnerships – sector wide, inter sectoral and with professional organisations, institutions, civil society and the private sector, is another important element of the systems thinking approach.

The management imperatives include leveraging of technology, regular data on key performance indicators, data triangulation and concurrent evaluation for monitoring and mid course correction wherever necessary. Quality Assurance leading to an overall culture of excellence is another key imperative.

Under the planning imperative, moving beyond the concept of high focus states, **there is now a focus on poor performing geographic pockets**, i.e. 264 districts spread across 24 states accounting for more than 70% of MMR, over 60% of IMR, and a high TFR. These have been identified for concerted action to address wide intra state disparities. Further, **Adolescent Health**, presently the weakest pillar under RCH, receives high priority with a framework driven by counselling, clinics, communications and convergence being proposed to complete the spectrum of RCH services.

**The planning imperative emphasises dismantling of verticalities. Thus a National Health Mission that subsumes both the NRHM and the upcoming National Urban Health Mission (NUHM) has been proposed so that greater integration of health programs is achieved.**

The implementation framework envisages leveraging the central funding, which is steadily expanding, to persuade states to follow the strategy and making releases contingent on phased progress with regard to management imperatives.

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<sup>6</sup> Prüss-Üstün, Annette; Bos, Robert, et al 2008: "Safer water, better health"; World Health Organization, Geneva

## 1. RATIONALE FOR A NEW STRATEGY

### Context

1.01 The need to rectify the historical underinvestment in health through progressively scaled up investment (from 1.3% to 3% of GDP) once the states developed appropriate absorptive capacity was acknowledged under the National Rural Health Mission and accordingly the 11<sup>th</sup> Plan period saw a substantial increase in public investment in health. The plan outlay for health increased from Rs 36,378 crore in the 10<sup>th</sup> plan to Rs 1,36,147 crore in the 11<sup>th</sup> plan out of which over Rs. 80,000 crores are earmarked for Family Welfare.

1.02 As a result, funding to the tune of Rs. 55,000 crores has become available to States during the period 2005-06 to 2010-11 under NRHM, of which 85% is central funding, largely for family welfare. Augmented federal funding backed by flexibility in how states approach the myriad challenges of health care, was expected to result in dramatic health systems reform and revitalisation of health service delivery, particularly at the level of primary health care and in the area of family welfare comprising broadly of reproductive and child health, immunisation and family planning

1.03 With an increase in financial allocation, there was optimism that high maternal and infant mortality would decline and fertility rates would stabilise. In this scenario national goals were set – an MMR of 100 per 1,00,000 live births, IMR of 30 per 1,000 live births and TFR of 2.1 by the year 2012<sup>7</sup>. These goals became the corner stone of Family Welfare Programme towards which states were to strive, duly enabled by the expected strengthening of health system.

### Situational Analysis

1.04 MMR is estimated at 254 per 100000 live births (SRS 2006); IMR is 53 per 1000 (SRS 2008) and TFR stands at 2.6 (SRS 2008). There are concerns that rate of reduction seems to have slowed down or at best stagnated compared to pre-RCH II/ NRHM period between year 2000 to 20005. Progress across states is highly uneven and some of the high focus states accounting for the highest rates of MMR, IMR and TFR have actually slid notwithstanding substantial additional public investment. The most backward areas/ districts/ vulnerable groups within states do not seem to have received the focus envisaged.

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<sup>7</sup> Goals initially set for the RCH II period of 2005-10, were subsequently subsumed under NRHM, and extended to 2012 to make them co-terminus with the NRHM period.

1.05 MMR has declined from 301 (2001-03) to 254 (2004-06); by about 16 points per year, whereas to achieve the NRHM target of 100 by the year 2012, average annual reduction ought to have been nearly 22 points. IMR reduction during pre- NRHM period (2001-05) was 2 points per year where as during 2005-08 it was only 1.67 points per year (see table 1 below) as against the expected reduction rate of 4.00 per year. TFR reduction during 2005-08 was 0.10 points per year against the expected annual rate of 0.11.

**Table 1: Average annual decline in MMR, IMR and TFR: desired vs. actual**

Indicator	Target 2012	Status SRS 2000	Status SRS 2005	Current status (SRS 2008)	Average decline/ year required between 2005-12 to achieve target	Actual Average decline/ year	
						2000-05	2005-08
IMR	30	68	58	53	4.00	2.00	1.67
TFR	2.1	3.2	2.9	2.6	0.11	0.06	0.10
MMR <sup>8</sup>	100	327	301	254	22.33	13.00	15.67
<b>Note: WHO estimates (2008) show MMR as 230, pointing to a further decline in progress</b>							

1.06 Two factors often cited for this gap between expected outcomes and outcomes are geographical and socio cultural diversity across states and the fact that health is a state subject. Thus, governance of health services becomes “actor” driven heavily influenced by the state’s overall political/ governance climate making homogenous implementation and even success difficult to hope for. But are these reasons good enough?

1.07 Interestingly, the experience of earlier Family Welfare programmes i.e. Child Survival and Safe Motherhood and Reproductive and Child Health Phase-I has not been much different and has been attributed to “an unconnected patchwork of efforts”<sup>9</sup> (Vora, Mavalankar et al). RCH-1 programme was officially termed as unsatisfactory by the World Bank in its end of project report. It is therefore important to carry out in depth analyses of the reasons for weak implementation of rather well conceived programs, and propose a strategic framework that effectively addresses the factors impeding progress on the ground.

1.08 Strife-torn countries like Sri Lanka, poorer countries like Bangladesh and large countries like Brazil have recorded accelerated improvements in health indicators in short periods of time. The following table shows a comparison of MMR and IMR with some comparable countries in the region and beyond:

<sup>8</sup> For MMR: 327 is as per SRS 1999-2001; 301 as per SRS 2001-03; and 254 as per SRS 2004-06; average decline is taken between 2001-2003 and 2003-2006.

<sup>9</sup> Kranti S. Vora, Dileep Mavalankar et al: “Maternal Health situation in India, a case study”.

**Table 2: International Comparison on MMR and IMR**

MMR		IMR	
➤ India	254	➤ India	53
➤ Bangladesh	570	➤ Bangladesh	52
➤ Pakistan	320	➤ Pakistan	78
➤ Sri Lanka	58	➤ Sri Lanka	11
➤ Brazil	110	➤ Brazil	19

1.09 The paper thus argues for a systems based and practical approach to improving performance of the public health system. It advocates putting in place institutional mechanisms that will work on principles of accountability, equity and the right to health care. The premise of the paper is that if simple management principles are put in place and adhered to, implementation can be accelerated to achieve improved maternal and child health outcomes<sup>10</sup>. The systemic approach will facilitate institutional strengthening and help in building a credible health care delivery system which will last longer than any programmatic duration/ project cycle.

## **2. VISION GUIDING THE NEW STRATEGY**

2.01 The existing vision, mission, objectives and functions of the Ministry of Health and Family Welfare are at Annex 2.

2.02 **Vision: “Give every woman and child the chance to live and be healthy.”**

2.03 **Objectives:**

- a) To build an accessible, equitable, affordable and accountable health system that offers multi level and comprehensive reproductive and child health care in an integrated manner and inspires public confidence;
- b) To accord priority to removing inequities, given the wide inter State and intra State disparities, rural - urban divide, gender imbalance and vulnerability of disadvantaged and marginalised sections;
- c) To adopt an inter sectoral approach to holistic health of women and children determined in large measure by clean environment, basic sanitation, nutrition, safe drinking water, hygiene, appropriate feeding practices, education, gender equality and women empowerment;

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<sup>10</sup> Annex 1 provides the current status on RCH goals and underlying indicators, key strategies, issues, and way forward for RCH components of maternal health, child health, immunization, family planning, and adolescent health.

- d) To lay emphasis on preventive and promotive health care through increased awareness, vigorous IEC, effective BCC, promotion of healthy life styles, revitalisation of local health traditions and inclusion of AYUSH;
- e) To recognise the paramount importance of community ownership, civil society engagement and PRI leadership in steering progress;
- f) To forge appropriate partnerships with the private sector to supplement the public health system, particularly in under / un served areas; and
- g) To encourage innovative and context specific health action and approaches.

### 3. GOALS

3.01 The following are the key goals for RCH under NRHM, for the year 2012:

- a) To bring down MMR to <100 per 1,00,000 live births
- b) To bring down IMR to <30 per 1,000 live births
- c) To bring down TFR to <2.1

3.02 Notwithstanding the slow progress towards attainment of these goals, effective implementation through a systems thinking approach is likely to result in acceleration of pace. The goals, however, may need to be appropriately refreshed at the end of 2012.

### 4. SWOT ANALYSIS

An analysis of the past five years of implementation of Reproductive and Child Health Program Phase-II under the National Rural Health Mission shows the following strengths and weaknesses, opportunities and threats:

Strengths	Weaknesses
<ul style="list-style-type: none"> <li>• Institutional frameworks for decentralised planning &amp; flexible financing (district health planning taken up by 631 out of 642 districts; nearly 30,000 registered Rogi Kalyan Samitis/ RKS set up at PHC and above)</li> <li>• Initiation of Communitisation – Village Health &amp; Sanitation Committees (VHSCs), Accredited Social Health Activists (ASHAs)</li> <li>• Augmentation of HR (over 1 lakh personnel</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of systems thinking</li> <li>• Continued verticality in management of health programs</li> <li>• Weak implementation in many states</li> <li>• Vulnerable populations/ areas inadequately addressed</li> <li>• Inadequate emphasis on accountability</li> <li>• Weak monitoring and supervision</li> </ul>



<p>engaged; including nearly 8650 doctors, 1600 specialists, 8000 AYUSH doctors, 25800 staff nurses, 46300 ANMs, and 17600 paramedics)</p> <ul style="list-style-type: none"> <li>• Upgradation of physical infrastructure (construction of new health facilities completed for 5519 sub centres, 414 PHCs, 240 CHCs, and 20 District Hospitals; strengthening of physical infrastructure of existing facilities on going)</li> <li>• Mechanisms for speedy transfer of funds</li> <li>• Strengthening of managerial capacity (over 1700 programme management personnel engaged at state, district and block levels)</li> <li>• Emphasis on innovations by states</li> <li>• Encouragement of context specific interventions</li> </ul>	<ul style="list-style-type: none"> <li>• Quality of services still a concern</li> <li>• Absence of focus on strengthening pre service education of HR in health, particularly nursing education</li> <li>• Limited capacity for trainings; weak management of training; poor utilisation of trained personnel</li> <li>• Lack of capacity building of Panchayati Raj Institutions (PRIs)/ VHSCs</li> <li>• Weakening Public Health focus</li> <li>• Lack of effective inter sectoral convergence</li> </ul>
<p><b>Opportunities</b></p> <ul style="list-style-type: none"> <li>• Enhanced central funding to states</li> <li>• Increase in absorptive capacity of states</li> <li>• Increased demand for services (e.g. from JSY)</li> <li>• Innovative ideas and projects being implemented by states</li> <li>• Availability of technology for expanding access (e.g. telemedicine), community interface (e.g. reaching out to clients with health related messages), monitoring (mother/ child tracking, mobile phones for real time data entry)</li> <li>• Nearly 8 lakh community health workers (ASHAs) on the ground</li> <li>• Over 4.51 lakh VHSCs can provide an excellent platform for inter sectoral convergence and local health action</li> <li>• Openness for partnerships with private sector and NGOs in public health</li> </ul>	<p><b>Threats</b></p> <ul style="list-style-type: none"> <li>• Reluctance on the part of states to increase spending on health</li> <li>• Weak governance</li> <li>• Sustainability of initiatives post NRHM/ 11<sup>th</sup> plan</li> <li>• Sustainability of additional HR provided under NRHM on contractual basis; absorption in regular stream questionable, unionism, legal complications</li> <li>• Loss of organisational memory and continuity on account of increasing reliance on contract staff who would leave at the project end or even in between.</li> <li>• PPP becoming a panacea for everything; with weak contracts and poor enforcement of agreed outcomes</li> <li>• Wastages and inefficiencies, central funding seen as easy money</li> </ul>

## 5. PROPOSED SOLUTIONS AND POLICY OPTIONS

5.01 Taking into cognizance the SWOT analysis presented above, the proposed strategy recognises that health care is a multifaceted challenge and involves multi pronged and comprehensive management. It traces unsatisfactory outcomes to lack of “systems thinking” on the part of states, leading to serious and multiple gaps that affect service delivery and diminish returns on investment. For instance, investments in First Referral Units (FRUs) are to a large extent nullified if there is an irrational deployment of doctors trained in comprehensive Emergency Obstetric Care (EmOC) and Life Saving Anaesthesia Skills (LSAS) with a stable tenure or/ and a system unable to ensure an optimal mix of HR, equipments, drugs, blood storage, referral transport and physical infrastructure etc. Costs incurred on training MBBS doctors in EmOC and LSAS (Rs. 2.80 lakh per doctor) turn wasteful if posted to PHCs that do not offer emergency obstetric services<sup>11</sup>. Additionally costs of equipment, facility up gradation etc cease to be productive investments and become wasteful as the FRU remains non functional. The promise of free institutional delivery is not kept if systems to ensure uninterrupted flow of drugs and consumables to all facilities and prevent stock outs are not in place as is today the case in many states. Instead, out of pocket expenses for pregnant women spiral and propaganda prescriptions flourish. Similarly, absence of a system to ensure functionality of diagnostic facilities adds to costs and hardship for the poor resulting in erosion of public faith in government facilities. The inability to run an assured, reliable and affordable referral transport network in many states makes it harder for a high risk pregnant woman to access a functional FRU in time and thus becomes an important factor for failure of program objectives. There is also a common failure regarding clear articulation of entitlements e.g. are the deliveries in public health facilities completely free of cost and if not, what does the pregnant woman pay for? What drugs are to be supplied free in OPD or emergency and to what sections of population - all or BPL? Is the sick new born entitled to free referral transport? In the absence of clearly defined entitlements, planning for supplies becomes haphazard and services at the point of delivery end up being uneven and discretionary in most states.

5.02 In the absence of systems thinking by states, even basic and rudimentary requirements such as general cleanliness, clean toilets, drinking water, electricity, clean linen, biomedical waste management etc. are many a time missing in public health facilities, leading to poor housekeeping and highly compromised perceived value. Issues of diet to patients and facility of stay for attendants also remain by and large unaddressed.

5.03 Shortage of human resources in health, inadequacy of their skill sets, absenteeism among doctors and other health service providers and suboptimal level and quality of their

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<sup>11</sup> As at August 2010: nearly 20% each of available Ob/ Gyns, anaesthetists and paediatricians were reported by states to be posted at PHCs and other sub-district facilities that were not FRUs; and nearly 37% of EmOC trained doctors and 41% of LSAS trained doctors were yet to be posted at functional FRUs.

effort is a reality too stark to be ignored, especially since HR costs constitute a significant proportion of the total health outlay. There have been negligible efforts in States at developing accountability framework through designing incentives to propel performance. However, facility based monitoring of functionality that includes caseload evaluation or/and performance of service providers is hardly in place. HR substantially augmented under RCH / NRHM is contractual, yet contracts are renewed in routine in most states. As a result, inputs aimed at facility up gradation, augmentation of equipments, drugs and other supplies etc. have not resulted in commensurate outputs. For instance, despite addition of 3 staff nurses for each 24x7 PHC, many of these PHCs may not have shown improved functionality. Skill sets of nurses are also reported as unsatisfactory, raising questions on the quality of nursing education. Though investments continue to be made in nearly 8 lakh ASHAs by way of training, drug kits etc and increased onus for community level health care support is being put on them, there is little appraisal of individual functionality. Most states have a large number of vacancies caused by inefficient system of recruitment. The shortage gets exacerbated in backward areas as service providers flock to coveted locations.

5.04 Systems capturing patient feedback and grievance redressal are largely nonexistent/ inadequately set up for any meaningful analysis and timely corrective action. Though NRHM design envisages community participation by way of Village Health and Sanitation Committees (VHSCs) and Rogi Kalyan Samitis (RKS), efforts at capacity building of PRIs and effective devolution of responsibilities have been weak in many states. As a result inter sectoral convergence, recognised as the key to effective outcomes, and best achieved at the village level, remains a distant dream. AWWs, ASHAs, ANMs, village school teachers, Gram / NREGA Sahayak who all could be harnessed for effective health education and local health action do not converge to the desired extent.

5.05 Verticality in health programs and weakening focus on public health have made health management a much more formidable challenge and have impeded progress. Weak monitoring and attempts to capture far too many data elements, many of which lend themselves to easy manipulation being unverifiable, have resulted in little pressure on the system for improved outcomes. Civil Registration System has received little attention, thus forgoing a major opportunity to capture vital data.

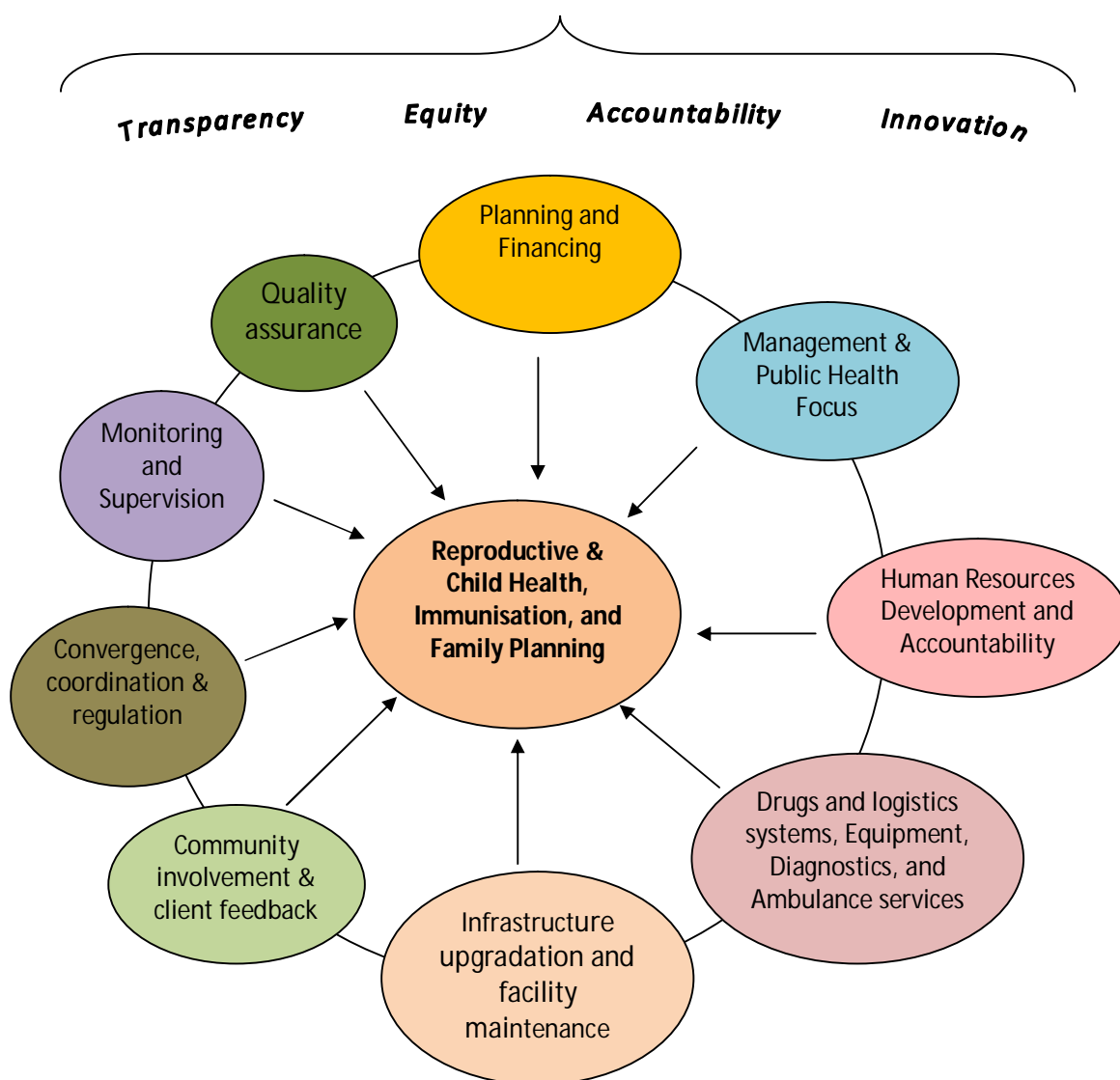
5.06 It is against this backdrop that the strategy puts forth an overarching framework driven by Peter Senge's model of "systems thinking".

## **PETER SENGE'S MODEL OF "SYSTEMS THINKING" – SEEING THE "WHOLE"**

5.07 The new strategic framework attempts to look at the challenge of achieving the goals as a "whole" and the interrelationships that it entails. It identifies, for action by states, **25 strategic areas** that act as system enablers, are highly interrelated (see figure 1

below) and thus become **management imperatives** for effective outcomes. Lack of attention to any of these would jeopardise the state's ability to render seamless and quality RCH service delivery and impede progress on RCH goals.

5.08 The management imperatives are underpinned by the principles of **transparency, equity, accountability and innovation**.



**Fig. 1: Inter relationship of the “management imperatives” and achievement of RCH outcomes**

5.09 The 25 management imperatives, for action largely by states, are detailed as under:

**Table 3: Management Imperatives**

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED BY STATES
<b>PUBLIC HEALTH PLANNING &amp; FINANCING</b>		
1.	Planning and financing	Mapping of facilities, differential planning for districts / blocks with poor health indicators; resources not to be spread too thin / targeted investments; addressing verticality in health programmes; planning for full spectrum of RCH services; least 10% increase in state health budget, over and above 15% share to NRHM resource envelope
2.	Management strengthening	Full time Mission Director for NRHM and a full-time Director/ Jt. Director/ Dy. Director Finance, not holding any additional responsibility outside the health department; fully staffed programme management support units at state, district and block levels; training of key health functionaries in planning and use of data
3.	Developing a strong Public Health focus	Induction training for all key cadres; public health training for doctors working in health administrative positions; resolution of cadre issues; strengthening of public health nursing cadre
<b>HUMAN RESOURCES</b>		
4.	HR policies for doctors, nurses paramedical staff and programme management staff	Minimising vacancies; timely recruitment; transparent selection; career progression; professional development; rational deployment; skill utilisation; stability of tenure; sustainability of human resources under RCH / NRHM
5.	HR Accountability	Facility based monitoring; incentive for both the health service provider and the facility, based on functioning; performance appraisal against benchmarks; renewal of contracts/ promotions based on performance; incentives for performance above benchmark; incentives for difficult areas
6.	Medical, Nursing and Paramedical Education (new institutions and upgradation of existing ones)	Enhanced supply of doctors, nurses, ANMs, and paramedical staff; mandatory rural posting after MBBS and PG education; expansion of tertiary health care; use of medical colleges as resource centres for national health programmes; strengthening/ revamping of ANM / GNM training centres and paramedical institutions; re-structuring of pre service education; developing a highly skilled and specialised nursing cadre

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED BY STATES
7.	Training and capacity building	Strengthening of State Institutes of Health & Family Welfare (SIHFW)/ District Training Centres (DTCs); quality assurance; availability of centralised training log; monitoring of post training outcomes; expanding training capacity through partnerships with NGOs / institutions; up scaling of multi skilling initiatives; management training for clinicians in administrative positions
<b>STRENGTHENING SERVICES</b>		
8.	Policies on drugs, procurement system and logistics management	Articulation of policy on entitlements, e.g. free vs. charged drugs for out patient/ in patient/ emergency patients, free vs. charged deliveries etc.; rational prescriptions; timely procurement of drugs and consumables; smooth distribution to facilities from the district hospital to the sub centre; uninterrupted availability to patients; minimisation of out of pocket expenses; quality assurance; prescription audits; essential drug lists (EDL) in public domain; computerised drugs and logistics MIS system
9.	Equipments	Availability of essential functional equipments in all facilities; regular needs assessment; timely indenting and procurement; identification of unused/ faulty equipment; regular maintenance and MIS
10.	Ambulance Services and Referral Transport	Availability of ambulances for critical patients; reliable, assured and affordable transport for pregnant women and newborn/ infants; clear policy articulation on entitlements both for mother and newborn; establishing control rooms for timely response and provision of services; drop back facility
11.	New infrastructure and Maintenance of buildings; sanitation, water, electricity, laundry, kitchen, facilities for attendants	New infrastructure, especially in backward areas; 24x7 maintenance and round the clock plumbing, electrical, carpentry services; power backup; cleanliness and sanitation; upkeep of toilets; proper disposal of bio medical waste; drinking water; water in toilets; electricity; clean linen; kitchens, facilities for attendants
12.	Diagnostics	Rational prescription of diagnostic tests; reliable and affordable availability to patients; partnerships with private service providers; prescription audits
<b>COMMUNITY INVOLVEMENT</b>		
13.	Patient's feedback and grievance redressal	Feedback from patients; expeditious grievance redressal; analysis of feedback for corrective action

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED BY STATES
14.	Community Participation	Active community participation; empowered PRIs; strong VHSCs; social audit; effective Village Health & Nutrition Days (VHNDs), strengthening of ASHAs, policies to encourage contributions from public/ community
15.	IEC	Comprehensive communication strategy with a strong behaviour change communication (BCC) component in the IEC strategy; dissemination in villages/ urban slums/ peri urban areas
<b>CONVERGENCE, COORDINATION &amp; REGULATION</b>		
16.	Inter Sectoral convergence	Effective coordination with key departments to address health determinants viz. water, sanitation, hygiene, nutrition, infant and young child feeding, gender, education, woman empowerment, convergence with SABLA, SSA, ICDS etc.
17.	NGO/ Civil Society	Mechanisms for consultation with civil society; civil society to be part of active communitisation process; involvement of NGOs in filling service delivery gaps
18.	Private Public Partnership (PPP)	Partnership with private service providers to supplement governmental efforts in underserved and vulnerable areas for deliveries, family planning services and diagnostics
19.	Regulation of services in the private sector	Clinical Establishment Act; quality of services, e.g. safe abortion services; adherence to protocols; checking unqualified service providers; quality of vaccines and vaccinators, enforcement of PC-PNDT Act
<b>MONITORING &amp; SUPERVISION</b>		
20.	Strengthening data capturing, validity / triangulation	100% registration of births and deaths under Civil Registration System (CRS); capturing of births in private institutions; data collection on key performance indicators; rationalising HMIS indicators; reliability of health data / data triangulation mechanisms
21.	Supportive Supervision	Effective supervision of field activities/ performance; handholding; strengthening of Lady Health Visitors (LHVs), District Public Health Nurses (DPHNs), Multi purpose Health Supervisors (MPHS) etc.
22.	Monitoring and Review	Regular meetings of State/ District Health Mission/ Society for periodic review and future road map; clear agenda and follow up action; Regular, focused reviews at different levels viz.

S. NO.	STRATEGIC AREAS	ISSUES THAT NEED TO BE ADDRESSED BY STATES
		Union Minister/ Chief Minister/ Health Minister/ Health Secretary/ Mission Director/ District Health Society headed by collector/ Officers at Block/ PHC level; use of the HMIS data for reviews; concurrent evaluation
23.	Quality assurance	Quality assurance at all levels of service delivery; quality certification/ accreditation of facilities and services; quality management systems
24.	Surveillance	Epidemiological surveillance; maternal and infant death review at facility level and verbal autopsy at community level to identify causes of death for corrective action; tracking of pregnant women and newborns
25.	Leveraging technology	Use of GIS maps and databases for planning and monitoring; GPS for tracking ambulances and mobile health units; mobile phones for real time data entry; video conferencing for regular reviews; closed user group mobile phone facility for health staff

5.10 Embedded in this framework of management imperatives are the following key policies which appear quite obvious and yet are grossly neglected by states resulting in sub-optimal outcomes:

- A human resources accountability framework, for incentivising performance while also building systems to take corrective action for lack thereof;
- Differential financing to facilities, based on their case load, including results based financing for improved performance;
- Backward district focus – differential planning, focussing on intra-state disparities in health outcomes – areas where the problem is the largest and the need for attention and resources the highest
- Developing a highly skilled and specialised nursing cadre to ensure care at different levels of health facilities;
- Clear articulation of entitlements for drugs, diagnostics, referral transport and other services; universal access to essential drugs; free deliveries in public health facilities;
- Developing a comprehensive framework for Adolescent Health, currently the weakest link in the continuum of health, and one that can have a significant impact on reduction of MMR, IMR, and TFR.



- At the central level, a National Health Mission, subsuming the current National Rural Health Mission and the upcoming National Urban Health Mission, is recommended for more integrated and comprehensive provision of services.

5.11 Some of the more important management imperatives are discussed below.

### **Management and Human Resource Imperatives**

5.12 Given the fact that health is most of all a management challenge that requires highly trained and committed health managers, the first and foremost imperative relates to strengthening management capacities at different levels within the state health department. Since the merger of the public health and medical services cadres, focus on public health is considerably weakened resulting in greater attention to ex post facto management of disease and illness. Health administrators need to be adequately trained in public health so that disease is averted and public health indices improve. States thus need to develop policies and systems suited to their context to redevelop a strong public health orientation. Medical Colleges would be required to redesign the MBBS module on public health and community medicine and add diploma/ PG seats in this discipline.

5.13 Further, in view of the centrality and importance of the role that service providers i.e. doctors, nurses, ANMs, paramedics and health supervisors play and in whom a significant proportion of the funds are invested in the framework, it lays emphasis on addressing issues, so far not addressed, pertaining to efficient human resource management by way of policies aimed at:

- a) Expeditious and transparent recruitment (e.g. walk in interviews for doctors as in Haryana, merit based criterion with preference for local service providers);
- b) Sensitisation to public health functions (e.g. induction training/ course in public health, as in Tamil Nadu where health functions are managed by doctors having formal qualifications in public health);
- c) Professional development (e.g. regular technical / managerial trainings), career progression (e.g. from ASHAs to ANMs to GNMs to Nurse practitioners through opportunities for lateral admission in nursing schools);
- d) Conducive working environment (e.g. exemption of specialists from post mortem/ casualty duties, sufficient OT days, provisioning necessary equipments etc. to enable them to do speciality related work);
- e) Rational deployment (e.g. posting of specialists only to FRUs/ hospitals as has been done by Chhattisgarh, and skilled birth attendants (SBAs) to facilities where deliveries take place);

- f) Stability of tenure (to guard against frequent transfers), as being done in Maharashtra through a Transfer Act for all government servants;
- g) Incentives for difficult areas (to deal with HR shortages in remote/difficult terrains), as is being provided in some states (e.g. Chhattisgarh, Himachal Pradesh, Karnataka, Madhya Pradesh, Uttarakhand);
- h) Creation of regular HR positions in the state plan, policies to encourage assimilation of high performing contractual staff into regular cadres, and leveraging it as a performance incentive;
- i) Strengthening of supervisory cadres, currently neglected, for improved supportive supervision e.g. promotion/ posting/ capacity building of LHV/ DPHNs.

### **HR Accountability Framework**

5.14 It is imperative that the states design an accountability framework with the following prerequisites:

- a) *Clarify roles and responsibilities* – Many a time there is a lack of clarity about roles and responsibilities e.g. splitting responsibilities between the regular ANM and the 2<sup>nd</sup> ANM added under NRHM on contract; public health functions of the block medical officer who is a medical specialist
- b) *Set performance expectations* – It is important that certain performance benchmarks are clearly laid down, both for the facility and the individual service provider – e.g. expected no. of minimum deliveries/ ANC/ IUD/ children immunised per month per ANM at the sub centre; no. of deliveries/ sterilisations/ OPD/ IPD etc. per 24x7 PHC/ FRU/ hospital besides minimum output per staff nurse/ doctor etc.
- c) *Appraise Information* – The next step is to design a system to regularly obtain and appraise information in respect of both facilities and individual service providers on key performance parameters. This would entail setting up systems of facility based monitoring.
- d) *Performance based Incentives/ disincentives* – Finally, it is essential to design a system of performance based incentives and disincentives and enforce it following appraisal of performance against standards. It assumes special significance in light of the fact that regular pay scales of doctors and other service providers are driven by consideration of parity with other categories of employees but performance based incentives can fairly add to their compensation and incentivise good performance. Those falling short of performance could be supported in the short run through training in case

of skill gap etc. but must attract disincentives in the event of repeated non performance e.g. non renewal of contracts for the case of contractual HR.

e) *Differential Financing* – This model would also include result based financing for facilities whereby sub centres/ PHCs/ FRUs/ hospitals with functionality higher than benchmarks would receive higher untied funds and annual maintenance grants. This involves making suitable amendments in the existing NRHM framework which provides for uniform funding to all health facilities as per a stipulated formula regardless of functionality.

### **Augmenting HR**

5.15 The challenge of shortage of HR in health also needs to be addressed on priority. Many states, particularly in the North, have not taken timely steps to set up medical colleges, ANM / GNM training schools, and paramedical education institutions. The states therefore have to develop policies to set up/ expand/ upgrade medical colleges, nursing institutions and other paramedical schools in both government and private sector. Post graduate seats for doctors need to be increased, particularly in deficient specialties (i.e. anaesthesia, paediatrics, gynaecology, public health, family medicine, etc.) and PG admissions needs to be leveraged to encourage doctors to serve in rural areas. Approval process of MCI and DCI would need to become faster and more transparent.

### **Strengthening the nursing cadre**

5.16 A highly skilled nursing cadre has the potential to become the main pivot of health care at primary level. Given the shortage of doctors and their lack of willingness to serve in rural and difficult areas, the way forward lies in developing a strong and specialised cadre of nurses that can shoulder the bulk of responsibility with regard to maternal and child health, especially in management of common obstetric complications, providing safe abortion services, and ensuring essential newborn care. Presently, the quality of pre service education particularly of private nursing institutions leaves much to be desired and Indian Nursing Council (INC) would have to urgently review the content, curriculum and duration of these courses. Reforms would include increasing ANM and GNM course duration, introducing a six month apprenticeship in sub district facilities, certification based on output, and specialisation in midwifery and newborn care.

### **Imperatives with regard to Drugs, Diagnostics and Equipments**

5.17 An uninterrupted supply of all essential drugs and consumables to each one of the health facilities would require states to put in place reliable systems of procurement (e.g. Tamilnadu Medical Systems Corporation) besides sound systems of demand forecast,

indenting, supply, testing and issue of drugs as well as monitoring of consumption and stocks. Clear articulation of entitlements is a prerequisite so that out of pocket expenses for patients are minimised. As govt supply because of bulk order costs substantially less than the market rate, free supply of essential medicines (generic) to all OPD patients is possible, per capita cost being in the range of Rs. 10 per OPD patient as established in Haryana. This can be a major relief for the patients visiting public health facilities whose economic status is at best moderate. Similarly a normal institutional delivery costs around Rs. 300 (excluding the cost of service providers) and C section costs Rs. 1100. Though it is implied that delivery/ new born care would be free at a govt facility, in the case of lack of a clear articulation, there is scope for exploitation by unscrupulous elements who extract illegal fee from the patients. A policy of free institutional deliveries/ new born care in public health facilities must be put in place. Information regarding entitlements and lists of essential medicines to be given free must be put in public domain. Further, safety nets for the poor covering major illnesses of mothers and children need to be instituted.

5.18 That all essential equipments are available in every health facility and that they remain functional is an imperative. This would require the states to set up systems for identification of essential equipment, timely indenting, finalisation of technical specifications, and building in annual maintenance contracts. Equally important are policies governing user charges for lab and diagnostic tests. Empanelment of private diagnostic centres at fixed and reasonable rates to supplement government facilities would be necessary to ensure 24-hour services.

### **Ambulance Services**

5.19 An assured, reliable and affordable ambulance service accessible across the state is the life line for maternal and child health. Some successful models e.g. EMRI in A.P, Gujarat etc, Janani Express in M.P, 102 Swasthya Vahan Sewa Haryana have emerged. The common features are a universal toll free telephone no, centralised call centres, GPS fitted ambulances and drivers/ technicians trained in first aid/ life saving skills. Progress in this regard needs to be made in all states without exception, ensuring that policy provisions are made for a drop back facility post delivery. Entitlements of pregnant women/ newborns for free transport must be clearly articulated and put in the public domain.

### **Community participation and feedback**

5.20 Giving clients a voice is an imperative. Systems to capture patient feedback are by and large lacking in most states and therefore require utmost attention. Demand for better services could eventually generate much pressure on supply side for improvements.

5.21 Also needed are mechanisms to ensure the desired community participation and social audit. Systematic capacity building of PRIs and VHSCs would pave the way for

activation of VHSCs, effective local health action and inter sectoral convergence on key health determinants i.e. water, sanitation, hygiene and nutrition, promotion of female education and gender equity and the battle against detrimental myths and socio cultural practices e.g. child marriage, bathing at birth, delayed breast feeding on account of customs etc. An integrated and comprehensive strategy at behaviour change communication is vital for success of health programs aimed at reproductive and child health and family planning.

5.22 Innovative ways to encourage contributions, in cash and kind, by the community/ public donations towards strengthening of health infrastructure i.e. buildings, equipments, ambulance etc. must be actively explored and clear policies laid down e.g. naming the donated building as per the donor's wish, setting up a fund for public contribution with exemption under 80 (G) of the Income Tax Act. It is surprising that most states lack a clear policy in this regard, thus frustrating even the most genuine and willing donors.

### **Inter Sectoral Convergence**

5.23 As stated in the vision, a lot of action to attain favourable health outcomes rests with Ministries/ departments outside health. For instance, improved female literacy and education, promoted by the HRD Ministry, directly impacts the age of marriage, the age of child bearing and the quality of child care which in turn has an enormously positive effect on reducing maternal and infant mortality. As per National Family Health Survey (NFHS-3) 2005-06, the Infant Mortality Rate is 50.4 for mothers in age group (20-29) years and is 76.5 for mothers with age less than 20 years.

5.24 Poor sanitation, a subject to be addressed by the Ministries of Rural/Urban Development, is estimated to cause half of India's malnutrition resulting in frequent infections and morbidity and mortality among women and children. Eradication of Polio is delayed because of poor environment resulting in gastro-enteric infections among children and leading to the digestive tract's inability to absorb the vaccine. Again the role of the Anganwadi in improving nutrition, immunization and health awareness is pivotal. Therefore, effective coordination with key departments to address health determinants viz. water, sanitation, hygiene, nutrition, infant and young child feeding, gender, education, woman empowerment is essential, given their overall impact on health. Convergence with other stakeholders like the Ministries of Women and Child Development, Rural Development, Panchayati Raj, Human Resource Development, Water and Sanitation, Sports and Youth Affairs and Urban Development will act as catalysts in making existing public health interventions more effective and efficacious and reducing the burden of morbidity and mortality. To illustrate, initiatives such as Indira Gandhi Matritva Sahyog Yojana (IGMSY) by MoWCD, launched in 51 districts as a pilot, could be implemented in the 264 high focus districts and aligned with Janani Suraksha Yojana (JSY) run by MOHFW to ensure

that the nutritional needs and the financial requirements of delivery etc. are adequately provided for. Similarly, the National Rural Livelihood Mission proposed by the Ministry of Rural Development could be piloted in the high focus districts.

5.25 In order to ensure effective inter sectoral coordination, that has so far eluded us despite explicit recognition of the same, it is felt that a committee headed by the Cabinet Secretary may be set up with representation from the concerned Ministries with the health Secretary as the Member Secretary

### **Data collection, quality, and validation**

5.26 Substantial efforts have been made in putting the web-based Health Management Information System (HMIS) in place at the national, state, district and facility level. However, the current perception is that with over 300 data elements to be captured on a monthly basis, and additional elements on quarterly and annual intervals, the quality of the data entered in the system needs closer monitoring and verification. A data triangulation framework needs to be developed for regular data validation. Key performance (“dashboard”) indicators need to be developed for the various programmes, which provide a quick and regular snapshot of progress across the states. Greater linkage needs to be developed with the Civil Registration System to capture data on private sector service delivery, which is significant in some states. Further, available technology needs to be better leveraged for real-time data collection (e.g. through mobile phones), and using data for planning and monitoring (e.g. through GIS maps and database).

### **Monitoring and Review Arrangements**

5.27 Recognizing lack of effective monitoring as one of the major factors for unsatisfactory progress, the systems thinking framework builds in the imperative for effective monitoring and review at all levels. It lays emphasis on regular monitoring from the lowest level of the Primary Health Centre headed by a Medical Officer, the level closest to the community, to the highest level i.e. State Health mission headed by the Chief Minister.

5.28 It advocates a bottom up approach for monitoring and reviews and therefore attaches utmost importance to the monthly meetings required to be held by the Medical Officer at the level of the PHC to monitor and review the functioning of ASHAs, VHSCs, ANMs, MPHW (M) and supervisors e.g. LHV and MPHS (M). It is at this level that the effectiveness and efficiency of public health programs and service delivery are most easily and productively reviewed sub centre/ village wise e.g. how active are the VHSCs, what support is required by not so active VHSCs, how many ASHAs are working satisfactorily, constraints that they face, their convergence with AWWs and other front line functionaries, health education activities, VHNDs, immunization session planning and coverage, ANC

checkups, distribution of IFA tablets, IUD insertions by ANMs etc. The list runs long but the importance of micro review for accelerated progress could hardly be overemphasized. It is at this level that primary data has to be captured, validated and further transmitted for reviews at higher levels.

5.29 Similarly, at the block level, monthly reviews by the Block Medical Officers, attended by the District health officers, is a significant part of the monitoring and review arrangements. This level would, in addition, review and ensure the availability of drugs, doctors, and other logistics for the next quarter. The gaps/ requirements would have to be communicated to the Chief Medical Officer (CMO) under intimation to the Collector. Such reviews, facility wise, could help identify the weak PHCs/ weak sub centres/weak programmatic areas/ gaps in supplies/ service providers etc and lead to timely and corrective action.

5.30 A district level monthly review will be held by the CMO with the Block Medical Officers. The results of this review, the progress on programs as well as the urgent requirements would be further reviewed at the level of the District Health Society headed by the district Collector. It would, however, be important to clearly state the KPIs that need monitoring at the level of the Collector, given the magnitude and complexity of the programmes and technical interventions thereunder.

5.31 Monitoring and Review, more intensively at the level of the Mission Director, NRHM and adequately by the Administrative Secretary, Health would be essential. Videoconferencing offers the advantage of frequent interaction without people having to travel long distances, too often. Quarterly meetings of the Executive Committee, NRHM under the chairmanship of the state Chief Secretary and of the Governing Body of the State Health Mission headed by the Chief Minister, at least twice a year, are critical for taking stock of and accelerating progress. Presently, these meetings are rather irregularly held in many states.

5.32 The importance of field inspections must be emphasized. Besides regular inspections by health officials, states must encourage inspections by PRIs, members of the Rogi Kalyan Samitis etc.

5.33 Facilities may be graded based on performance. Those found to be chronically performing poorly should receive the personal attention of the CMO/Collector/Mission Director. Disincentives should be enforced in case of persistent non-performance.

5.34 In order to ensure meaningful monitoring, suitable formats for inspections, collection of information and data would have to be designed. Careful analysis must be done and follow up action must be taken and documented for effective messaging and results.



5.35 Finally, periodic reviews of States' performance by MOHFW are envisaged. These are proposed at two levels- one with the state technical officers in charge of specific programs e.g. State immunization Officer/ State Family Planning Officer/ State RCH officer etc for in depth review of progress on program specific strategies and another with Mission Directors/Health Secretaries with regard to the overarching strategic framework and other program specific issues. Visits to states by MOHFW officials for state centric reviews and first hand assessment of progress on the ground is an important part of the monitoring and review arrangements.

### **Adolescent Health – the weakest pillar**

5.36 According to 2001 census data, there are 300 million adolescents, which comprise nearly one fifth (22%) of India's total population. Of these, nearly 10% are in the 15-19 years age group. Data from NFHS- 3 (2005-06) reports that teenage pregnancy is an important area to be addressed. One in six women in the age group of 15-19 begin childbearing, 12 percent of them have already become mothers. Adolescent mothers are at a higher risk of miscarriage, maternal mortality and stillborn or underweight babies. Mortality in adolescent females aged 15 to 19 years is higher than that among adolescents aged 10 to 14 years. More than 70% girls in the age 10 to 19 years age group suffer from severe or moderate anaemia (DLHS- RCH 2004). Fertility in the 15 to 19 years age group contributes to 19% of the total fertility rate. Among currently married women, the unmet need for contraception is the highest in the 15 to 19 years age group. Nearly 27% of married adolescent females have reported unmet need for contraception (NFHS- 3). Most sexually active adolescents are in late adolescence. Over 35% of all reported HIV infections in India occur among young people in the 15 to 24 years age group, indicating that young people are highly vulnerable. Majority of infections are through unprotected sex.

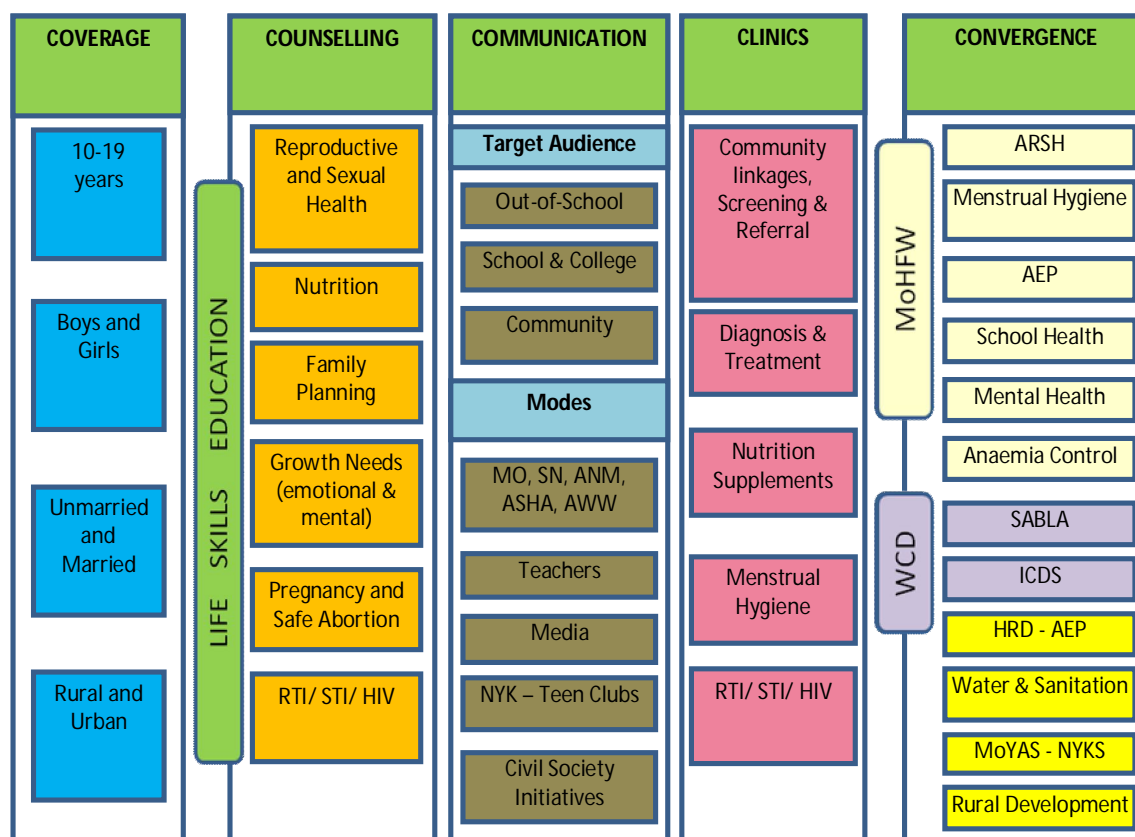
5.37 And yet there is no strategy in place for addressing adolescent health issues nor is there a division in MOHFW to deal with the subject. Against this backdrop, a new framework for adolescent health is conceptualised which includes strategies specific to both boys and girls in two sub groups – 10-14 and 14-19 in both rural and urban areas and covering unmarried as well as married adolescents. The strategy proposes to have an effective counselling mechanism at the village level addressing not just the adolescents but also the families and teachers. Service delivery for adolescents including diagnosis and treatment needs to ensure reproductive health including pregnancy and safe abortions, family planning, menstrual hygiene; nutrition supplements, mental health, prevention of substance abuse as well as protection against violence and sexual abuse.

5.38 This comprehensive adolescent health strategy requires convergence among various programmes within MoHFW including the existing ARSH strategy, school health, adolescent education programme(AEP) of NACO, mental health and anaemia control initiatives,



schemes of Ministry of Women and Child Development, Ministry of Youth and Sports Affairs as well as Ministry of Human Resources.

**Fig. 2: Framework for Adolescent Health**



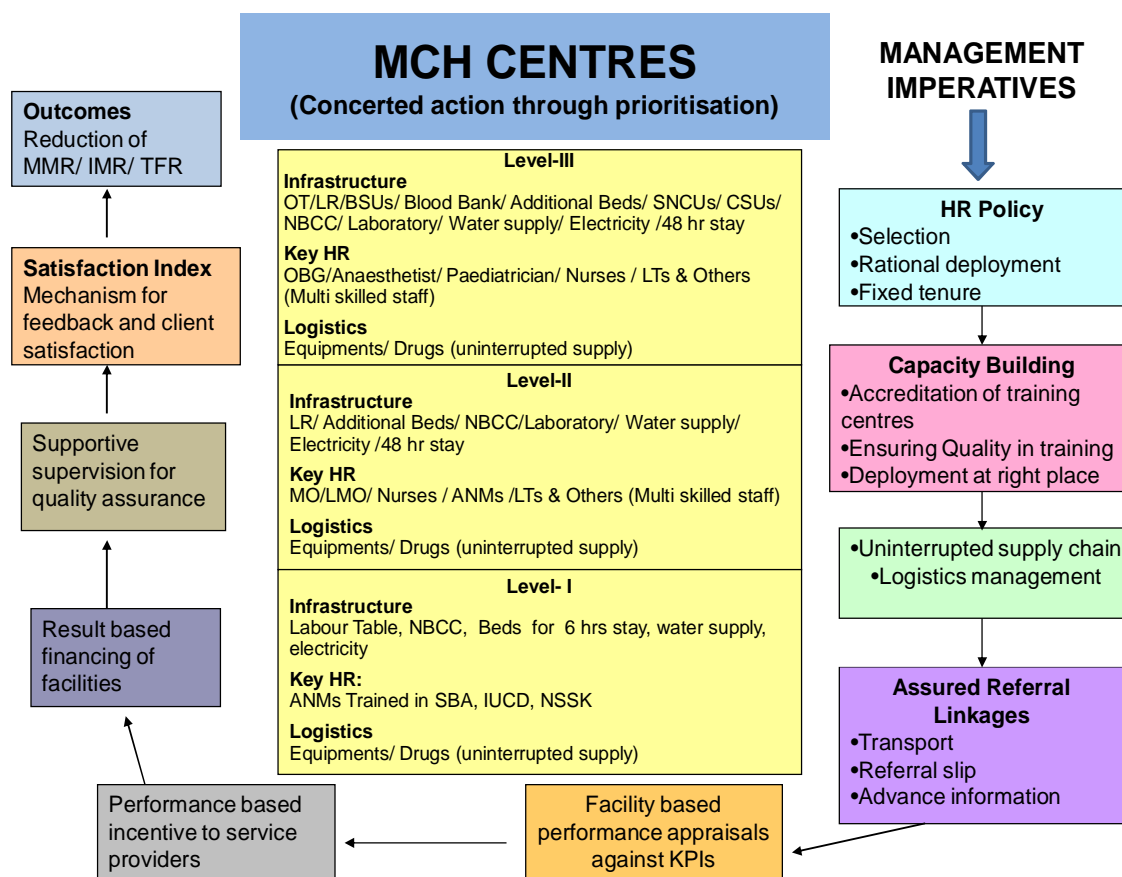
### Differential Planning: Focus on 264 backward districts

5.39 Available evidence points to continued neglect, by states, of pockets afflicted with the highest burden of MMR, IMR and TFR. There are about 264 districts spanning 24 states which account for more than 70% of the MMR, over 60% of IMR, and a high TFR. Notwithstanding increased funding under NRHM, these districts continue to be deficient in terms of physical infrastructure and HR at all levels. There is therefore an urgent need to look beyond high focus states to high focus districts across states and concentrate efforts in these 264 endemic districts for accelerated progress.

5.40 A key component of the above is improving quality of the health facilities where deliveries are being conducted – referred to as “MCH Centres” – in accordance with the standards laid down in the Maternal and Newborn Health Operational Guidelines and in

the Indian Public Health Standards<sup>12</sup>. As seen below, the success of the MCH centre strategy for enhancing RCH outcomes is dependent on “systems thinking” approach.

**Fig. 3: Inter-relationship between MCH centre strategy and management imperatives**



## National Health Mission

5.41 One of the key objectives of the National Rural Health Mission is to reform the health architecture and replace the existing verticality in health programs and structures with a highly integrated health system. The extent to which verticality has been addressed is debatable. In many states, integration of the Project Management Units set up under NRHM with the State health directorates has not happened with NRHM becoming a rather loose but resource rich externality. There is criticism that NRHM has become an end in itself rather than a means to lend support to, and strengthen implementation of programs such as RCH and Disease Control.

<sup>12</sup> A note on identification and strengthening of MCH Centres is provided at Annex 2.

5.42 On the anvil is the National Urban Health Mission, also proposed to be launched soon. While there is an urgent need to address the serious gaps in health infrastructure in urban areas, particularly urban slums and peri urban areas where public health indicators are extremely poor, there is a danger that the National Urban Health Mission (NUHM) may further accentuate verticality in health programs.

5.43 It is therefore recommended that both the NRHM and the proposed NUHM may be subsumed into a National Health Mission. The National Health Mission would serve as an overarching umbrella for RCH, Control of Infectious Diseases, and Non communicable and emerging diseases including geriatric care. Under each of these broad programmatic groupings, rural and urban interventions and allocations could be separately reflected besides focused interventions/ allocations for highly vulnerable/ difficult areas/ populations that may require concerted attention and action and a highly contextualised strategy that may warrant special dispensation and relaxation of general norms e.g. population norms for sub centre/ PHC/ CHC, staff ratios, local means of transport, home deliveries.

### **Linkages with Results Framework Document**

5.44 It is said that what gets monitored gets done. However, the real challenge lies in identifying the right success/ key performance indicators (KPIs). Failure to do so could lead to the tragedy of monitoring the wrong indicators and rendering the exercise quite futile. Further, KPIs need to be refreshed constantly as programs progress and program priorities evolve. For instance, in the first 2 years of NRHM, the monitoring priority related to how many ASHAs were recruited vs. how many were required and how many of those recruited were trained. The priority subsequently had to change to monitoring how many ASHAs were actually functional on the ground and to what extent. Thus the success indicator in the Results Framework Document (RFD) would need to change e.g. the average honorarium per ASHA per month. An ASHA can receive honorarium upto Rs. 2600 per month and if per capita honorarium is say Rs. 500 only, we need to wake up, investigate deeper and persuade states to set up systems to review individual performance and weed out non-performing ASHAs. Failure to evolve such a KPI would end up in monitoring the rather irrelevant parameter. As a result, investments would continue to be made in non-functional ASHAs (training, drug kits, mobility support etc) and program strategy would continue to rely more and more heavily on ASHAs for improved outcomes. Similarly, if the success indicator in the current RFD monitors simply the no. of Village health and Sanitation Committees against a given target, it may lead to erroneous decisions and misplaced investments by way of annual untied grants on a normative basis. Instead if the KPI were to monitor the average annual expenditure per VHSC, it may immediately give a broad indication of the extent to which VHSCs are active on the ground and participating in local health action. State wise/

district wise/block wise picture can be easily captured with regard to such KPIs for more focused analysis.

5.45 To take another example, the present RFD captures the no. of FRUs/ 24x7 PHCs/ no. of doctors trained in EMOC/ LSAS against the targets as success indicators whereas the fact of the matter is that many of these facilities may not be operational on the ground and may have little caseload as a result of weak management as already discussed under 5.01. In such a situation, average caseload per facility/service provider may be a more useful KPI. Similarly, rather than monitoring just the no. of children fully immunised (data which could be easily inflated by states being difficult to verify) as is being done under the present RFD, additional information on vaccine consumed, wasted and in stock is likely to give a fuller and truer picture of the progress under Universal Immunization Program. Further, under the present RFD, institutional deliveries only in government and accredited private facilities are reported whereas in many states, deliveries in non- accredited private institutions (and the no. is substantial) are not being captured and resultantly, the success indicator becomes incomplete.

5.46 Suffice it to say that the success indicators listed in the present RFD of the MoHFW in respect of Family Welfare/ RCH need to be extensively reviewed and redesigned. In view of the dynamic nature of the success indicators, the Ministries would need to be given the requisite flexibility to refresh the indicators in consonance with the changing programmatic requirements. As the action in health sector rests with the states which are at varying stages with regard to progress on key RCH goals, it would be necessary for the Ministry to put in place a RFD for states with state specific requirements duly built in.

## **6. PRIORITISATION OF PROPOSED SOLUTIONS AND POLICY OPTIONS**

6.01 The systems thinking approach necessitates co- terminus and coordinated action on all management imperatives, rather urgently. Given the present pace of progress on goals, there has to be a sense of urgency. However, it is appreciated that given the wide baseline divergence across states with regard to these imperatives, it would be unrealistic to expect all states to make equal progress at the same time. The table below thus looks at the various policy options envisaged in the new strategic framework and puts them in context of their priority, influence of the government in putting these in place, and the sequencing. It is acknowledged that it would require further refinement/readjustment in terms of listing the policy areas (it is presently not comprehensive) and the sequencing in consultation with the states and other stakeholders.

**Table 4: Prioritisation of proposed solutions and policy options**

S. NO.	STRATEGIC AREA / POLICY	PRIORITY	INFLUENCE	SEQUENCING
1.	States adopting a policy for differential financing/ enhanced resources for backward districts based on mapping/ health indicators	High	High	Short term
2.	Policy on mandatory public health training for doctors and nurses in administrative positions	High	Medium	Medium term
3.	Review of content, curriculum and duration of nursing courses	High	Medium	Medium term
4.	Developing a framework for strengthening of the nursing cadre, including career progression avenues.	High	Medium	Medium term
5.	Putting in place an HR Accountability framework	High	High	Short term
6.	Policy for rational transfer with stability of tenure	High	Medium	Medium term
7.	Increasing number of sanctioned posts, in line with functionality of health facilities	Medium	Low	Medium term
8.	Policy for absorption of contractual staff into regular service	Medium	Low	Medium term
9.	Incentive policy for service in difficult areas	High	High	short term
10.	Increasing number of seats in government medical and paramedical institutions	Medium	Medium	Medium term
11.	Policy for compulsory rural posting after MBBS and PG education	High	Medium	Medium term
12.	Policy on free delivery and abortion services at govt. health facilities for all	High	High	Short term
13.	Preparation of essential drug lists (EDL) for different levels of health institutions	High	High	Medium term
14.	Setting up of a drug / equipment procurement and logistics organisation / strengthening of existing entity	Medium	Medium	Medium term
15.	Policy on equipment maintenance at health facilities	High	High	Medium term
16.	Setting up of assured and affordable referral transport system, monitored and managed through call centres	High	High	Medium term

S. NO.	STRATEGIC AREA / POLICY	PRIORITY	INFLUENCE	SEQUENCING
17.	Policy on referral transport entitlements for pregnant women and newborns, including drop back from health facility	High	Medium	Short term
18.	Guidelines and action plan for maintenance of health facilities	High	High	Medium term
19.	Policy on diet for pregnant women for ensuring post delivery stay	High	High	Short term
20.	Policy on free/ affordable diagnostic services for maternity care	Medium	Medium	Medium term
21.	Policy on grievance redressal	High	High	Short term
22.	Policy to encourage contributions from public/ community	Medium	Low	Medium term
23.	Policy on setting up a PPP cell (in-house / outsourced)	High	High	Short term
24.	Development of a data triangulation framework	High	High	Medium term
25.	Approval and implementation of Clinical Establishment Act	High	Medium	Medium term
26.	Policy on conditional release of central funds, based on progress on management imperatives	High	High	Short term
27.	Development of a comprehensive Adolescent Health strategy	High	Medium	Medium term
28.	Development of the National Health Mission	Medium	High	Medium term

## 7. IMPLEMENTATION FRAMEWORK

7.01 The onus of implementation of the above strategic framework will lie with the States with guidance / assistance and oversight by the Centre. Participation of the various development partner agencies, civil society organisations and other departments / ministries will be crucial to the successful implementation and achievement of the enhanced health / RCH outcomes envisaged. One of the key tasks is consultations with the States and other stakeholders, in order to come to a shared understanding of the principles and agreement on the key implementation modalities, timelines and responsibilities.

7.02 Guidelines for several of the imperatives are already in place, e.g. use of untied grants for facility improvement; operationalising VHSCs and functioning of State and District Health Missions and Societies; accreditation of private providers for RCH services, including for training, etc. However, as highlighted above, the challenge has been to ensure implementation of the available guidelines/ strategies.

7.03 The strategy, as already stated, offers a highly practical framework for the states. To ensure that the states implement it in the right earnest, the following road map is contemplated:

- a) There is an acknowledgement on the part of the central government that though health is a state subject, there is a need for increased budgetary support to the states, given the key role that health plays in sustainable development. The central envelope for the states is thus poised to increase further to about 1,00,000 crores in the 12<sup>th</sup> Plan.
- b) It is proposed to leverage central funding as a trigger to effective and efficient delivery in accordance with the strategic framework comprising 25 management imperatives and policy options flowing there from.
- c) Releases to the states would be linked with the phased progress that they make with regard to the strategy imperatives. State Program Implementation Plans (PIPs) are required to be prefaced by their current status on each of the 25 management imperatives, their future road map along with timelines.
- d) The above approach would necessitate a paradigm shift within the central government in so far as a dim view is not taken of a lower than targeted expenditure at the central level. Presently, there is a pressure to release funds to states (to show adequate expenditure) and obtain utilisation certificates without insisting on commensurate outcomes. Judicious utilisation of central funds leading to improvement of health services and public health indicators has to be the aim instead of 100% release of budgeted amounts, passed on to states rather unquestioningly.
- e) Besides adherence to the strategic framework, a key conditionality for release of central funding would be at least a 10% annual increase in state plan for health so that greater commitment on the part of the state govt towards health systems strengthening is secured and central funding is not perceived as easy money or a way to substitute state spending on health. This would also prepare the states to take over the committed liabilities at the end of the centrally funded programs.
- f) It is proposed to set up an incentive pool for rewarding robust performance under NRHM. For this purpose, guidelines would be developed. Cost effective innovations

with potential for large impact and models of good governance and systems reforms would also attract bonus/ incentive by way of enhanced resource allocation.

7.04 A performance compact/ MOU is proposed to be put in place with every state to enforce the above conditionalities, keeping in view the state specific situation and circumstances. Due caution however needs to be exercised to avoid too much prescription by the central government e.g. universalisation of 24x7 PHCs/ FRUs, ASHAs, JSY, sterilization compensation and instead encourage states to evolve context specific, need based innovative approaches. On its part, MOHFW would proactively evaluate good practices and document and disseminate them.

7.05 The table below provides the key activities, with timelines and responsibilities for implementation of the proposed strategic framework but may need further revision in consultation with states:



**Table 5: Implementation framework for the proposed strategic framework and policy options**

S. NO.	ACTIVITY	RESPONSIBILITY	TIMELINE					
			YEAR 1				YEAR 2	YEAR 3
			Q 1	Q 2	Q 3	Q 4		
1.	Consultation meetings with States, development partners, civil society, other ministries, and other stakeholders to arrive at a shared understanding & agreement on proposed strategic framework.	Centre						
2.	Putting in place the performance compact with the states.	Centre						
3.	Providing differential and enhanced allocation of resources for backward districts.	States						
4.	Putting in place an HR Accountability framework	States						
5.	Developing a HR policy, including transfer policy with stability of tenure.	States						
6.	Reducing mismatch in deployment of available personnel	States						
7.	Increasing number of sanctioned posts, in line with functionality of facilities	States						
8.	Policy for absorption of contractual staff into regular service	States						
9.	Setting up systems for monitoring outputs / performance of facilities and service providers	States						
10.	Incentive policy for service in difficult areas	Centre & States						

S. NO.	ACTIVITY	RESPONSIBILITY	TIMELINE					
			YEAR 1				YEAR 2	YEAR 3
			Q 1	Q 2	Q 3	Q 4		
11.	Policy on mandatory public health training for doctors and nurses in administrative positions	States						
12.	Increasing number of seats in medical and paramedical educational institutions	States & Centre						
13.	Policy for compulsory rural posting after MBBS and PG education	States						
14.	Review of content, curriculum and duration of nursing courses	Centre, Indian Nursing Council						
15.	Developing a framework for strengthening of the nursing cadre, including career progression avenues.	Centre, Indian Nursing Council						
16.	Policy on free delivery and abortion services at govt. health facilities for all	States						
17.	Preparation of essential drug lists (EDL) for different levels of health institutions	States						
18.	Setting up of a drug / equipment procurement and logistics organisation/ strengthening existing entity.	States						
19.	Policy on maintenance of equipment at health facilities.	States						
20.	Setting up of assured and affordable referral transport system, monitored and managed through call centres.	States						
21.	Policy on referral transport entitlements for	States						

S. NO.	ACTIVITY	RESPONSIBILITY	TIMELINE					
			YEAR 1				YEAR 2	YEAR 3
			Q 1	Q 2	Q 3	Q 4		
	pregnant women and newborns, including drop back from health facility							
22.	Guidelines and action plan for maintenance of health facilities	States						
23.	Policy on setting up of a PPP cell (in-house/outsourced)	States						
24.	Setting up of a PPP cell (in-house / outsourced)	States						
25.	Policy to encourage contributions from public/community	States						
26.	Policy on grievance redressal	States						
27.	Policy on free / affordable diagnostic services for maternity care	States						
28.	Development of a data triangulation framework	Centre & States						
29.	Approval of Clinical Establishment Act	States						
30.	Documentation of state initiatives across the management imperatives	Centre & States						
31.	Workshops for dissemination of state initiatives across management imperatives	Centre						
32.	Consultative meetings for and development of a comprehensive Adolescent Health strategy	Centre						
33.	Consultative meetings for and development of the National Health Mission	Centre						

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## References

World Health Organisation, Geneva. *World Health Statistics, 2007*.

Report of the Office of the United Nations High Commissioner for Human Rights on preventable maternal mortality and morbidity and human rights, 2010.

UNICEF. *The State of the World's Children 2009: Maternal and Newborn Health (United Nations publication, Sales No. E.09.XX.1)*

Peter M. Senge: *The Fifth Discipline - The Art and Practice of the Learning Organization*, 1990

Prüss-Üstün A, Bos R, Gore F, Bartram J. Safer water, better health: costs, benefits and sustainability of interventions to protect and promote health. World Health Organization, Geneva, 2008

Kranti S. Vora, Dileep Mavalankar et al. 2009. *Maternal Health situation in India: case study*.

## KEY RCH INDICATORS

S. No.	State	MMR		IMR		TFR	
		SRS 2001-03	SRS 2004-06	SRS 2003	SRS 2008	SRS 2003	SRS 2008
	<b>India</b>	<b>301</b>	<b>254</b>	<b>60</b>	<b>53</b>	<b>3</b>	<b>2.6</b>
1	Andaman & Nicobar Islands <sup>#</sup>	--	--	<b>18</b>	<b>31</b>	--	--
2	Andhra Pradesh	195	154	59	52	2.2	1.8
3	Arunachal Pradesh <sup>#@</sup>	--	--	<b>34</b>	<b>32</b>	2.5	3
4	Assam	490	480	67	64	2.9	2.6
5	Bihar *	371	312	60	56	4.2	3.9
6	Chandigarh <sup>#</sup>	--	--	<b>19</b>	<b>28</b>	--	--
7	Chhattisgarh * <sup>^</sup>	379	335	70	57	3.3	3
8	Dadra & Nagar Haveli <sup>#</sup>	--	--	54	34	--	--
9	Daman & Diu <sup>#</sup>	--	--	39	31	--	--
10	Delhi <sup>^</sup>	--	--	<b>28</b>	<b>35</b>	2	2
11	Goa <sup>#@</sup>	--	--	16	10	1.8	1.8
12	Gujarat	172	160	57	50	2.8	2.5
13	Haryana	<b>162</b>	<b>186</b>	59	54	3	2.5
14	Himachal Pradesh <sup>#^</sup>	--	--	49	44	2.1	1.9
15	Jammu & Kashmir <sup>^</sup>	--	--	<b>44</b>	<b>49</b>	2.4	2.2
16	Jharkhand * <sup>^</sup>	371	312	51	46	3.5	3.2
17	Karnataka	228	213		45	2.3	2
18	Kerala	110	95	<b>11</b>	<b>12</b>	1.8	1.7
19	Lakshadweep <sup>#</sup>	--	--	26	31	--	--
20	Madhya Pradesh *	379	335	82	70	3.8	3.3
21	Maharashtra	149	130	42	33	2.3	2
22	Manipur <sup>#@</sup>	--	--	16	14	3	2.8
23	Meghalaya <sup>#@</sup>	--	--	57	58	4.6	3.8
24	Mizoram <sup>#@</sup>	--	--	<b>16</b>	<b>37</b>	2.9	2.9
25	Nagaland <sup>***@</sup>	--	--	<b>17</b>	<b>26</b>	3.8	3.7
26	Orissa	358	303	83	69	2.6	2.4
27	Puducherry <sup>#</sup>	--	--	24	25	--	--
28	Punjab	<b>178</b>	<b>192</b>	49	41	2.3	1.9
29	Rajasthan	445	388	75	63	3.8	3.3
30	Sikkim <sup>#@</sup>	--	--	<b>33</b>	<b>33</b>	2.8	2
31	Tamil Nadu	134	111	43	31	1.9	1.7
32	Tripura <sup>#@</sup>	--	--	<b>32</b>	<b>34</b>	1.9	2.2
33	Uttar Pradesh *	517	440	76	67	4.4	3.8
34	Uttarakhand * <sup>#@</sup>	517	440	<b>41</b>	<b>44</b>	2.6	
35	West Bengal	194	141	46	35	2.3	1.9

MMR: \* Combined data for Bihar–Jharkhand; MP–Chhattisgarh; and UP–Uttarakhand.

For smaller states & UTs, MMR data is not individually collected/ available due to small samples.

IMR: <sup>#</sup> Data for smaller states & UTs is for preceding three years, i.e. 2001-03 & 2005-07 respectively

\*\* SRS data for 2004 is provided, since data for 2003 is not available

TFR: <sup>^</sup> SRS data for 2004 is provided, since data for 2003 is not available

@ NFHS-2 (1998-99) and NFHS-3 (2005-06) data is provided for states where SRS data is unavailable.

Sl. No.	State / UTs	Mothers who had 3 or more Ante Natal Check-ups	Mothers who had full Ante Natal Check-up	Institutional delivery	Children 12-23 months fully immunised	Children 12-23 months who received measles vaccine	Early Initiation of breast feeding (within one hour of birth)	Children under 2 years of age who had diarrhoea in preceding 2 weeks who received ORS	Married women aged 15-49 years using any modern contraceptive	Total unmet need for family planning
	<b>INDIA</b>	<b>49.8</b>	<b>18.8</b>	<b>47</b>	<b>54</b>	<b>69.5</b>	<b>40.5</b>	<b>34.2</b>	<b>47.1</b>	<b>21.3</b>
1	A&N Islands	79.5	48.6	76.4	83.6	92.8	76.1	71.8	67.4	12.9
2	Andhra Pradesh	89.4	40.5	71.8	66.7	88.4	47.5	43.8	66.7	8.1
3	Arunachal Pradesh	46.3	5.4	47.6	13.3	32.5	38.2	64.6	48.2	13.3
4	Assam	45	8.5	35.1	50.7	64.2	64.9	34.9	31	23.6
5	Bihar	26.3	4.6	27.5	41.4	54.1	16	22	29.4	35.9
6	Chandigarh	77.6	30.2	76.1	73	87.3	50.3	34	72.1	8.2
7	Chhattisgarh	51.1	13.7	18	59.3	80	49.6	36.3	48.7	19.9
8	Dadra & Nagar Haveli	63.2	23	44	57.9	84.7	52.2	49.8	52.7	19.5
9	Daman & Diu	87.4	43.4	64.1	85.7	90.9	38.6	32.2	54.3	16.6
10	Delhi	71.7	33.6	68.7	67.3	83	29.1	48.5	55.2	13.9
11	Goa	95.8	90.9	96.4	89.8	94.1	60.9	69.9	37	26.6
12	Gujarat	54.8	19.9	56.4	54.8	72.6	48	36.7	56.4	15.6
13	Haryana	51.8	13.2	46.8	59.6	69	16.5	31.7	55.7	15.4
14	Himachal Pradesh	59.4	31.4	48.3	82.2	94.2	56.5	60.7	69.5	14
15	Jammu & Kashmir	73.3	29.1	54.9	62.2	81.3	54.1	53	42.7	20.6
16	Jharkhand	30.5	9	17.7	54	70.6	34.5	21.4	31.8	33.5
17	Karnataka	81.2	51	65.1	76.7	85.1	46.5	46.1	62.3	14.9
18	Kerala	95.2	72.2	99.4	79.6	87.9	64.6	45.6	55.9	15.8
19	Lakshadweep	91.4	68.2	90.7	86.2	92.1	69.7	55.8	16.5	27.3
20	Madhya Pradesh	34	8.6	46.9	36	57.4	42.7	30	54.8	18.2

Sl. No.	State / UTs	Mothers who had 3 or more Ante Natal Check-ups	Mothers who had full Ante Natal Check-up	Institutional delivery	Children 12-23 months fully immunised	Children 12-23 months who received measles vaccine	Early Initiation of breast feeding (within one hour of birth)	Children under 2 years of age who had diarrhoea in preceding 2 weeks who received ORS	Married women aged 15-49 years using any modern contraceptive	Total unmet need for family planning
21	Maharashtra	74.4	33.9	63.5	69	84.5	52.5	44.2	63.9	13.6
22	Manipur	57.2	12.3	41	47.4	58	56.8	51.6	19.5	25.8
23	Meghalaya	39.5	14.4	24.5	33.1	51.9	73.6	45.5	17	32.4
24	Mizoram	62.4	32.9	55.7	54.2	80.7	77.5	54.9	56.7	14.2
25	Orissa	54.5	23.3	44.1	62.3	81	63.2	49	39.6	23.1
26	Puducherry	87.8	48.6	99	80.2	91.2	69.6	53.8	59	19.4
27	Punjab	64.6	14.3	63.1	79.8	89.1	44.1	52	63.2	11.4
28	Rajasthan	27.6	6.6	45.4	48.7	67.3	41.4	30.6	55.3	16.9
29	Sikkim	69.8	27.4	49.5	76.8	92.3	63.6	47.8	59.8	16.2
30	Tamil Nadu	95.6	51.8	94	81.6	95.5	76.1	37.5	59.2	18.1
31	Tripura	43.9	13.2	46.2	38.2	51.4	40.8	58.8	40.6	12.9
32	Uttar Pradesh	21.8	3.3	24.5	30.2	46.9	15.1	17.4	27.2	32.6
33	Uttarakhand	32.2	15.6	30	62.9	82.3	63.5	43.6	58.9	20.1
34	West Bengal	66.9	19.6	49.1	75.7	82.8	38.5	46.4	53.4	11.1

SOURCE: District Level Household Surveys, 2007-08

**REPRODUCTIVE & CHILD HEALTH**  
**COMPONENT SPECIFIC STRATEGIES, ISSUES & WAY FORWARD**

**A. MATERNAL HEALTH**

**I. Key strategies**

***Demand Promotion:*** Janani Suraksha Yojana

***Services:***

- a. Essential and Emergency Obstetric Care
  - Quality antenatal and post natal care
  - Strengthening referral transport systems
  - Skilled Attendance at birth (domiciliary & health facilities)/ SBA Training
  - Operationalise facilities- FRUs, 24 x7 PHCs.
  - Multi-skilling of doctors to overcome shortage of critical specialities (training on Life saving Anaesthesia Skills and Emergency Obstetric Care).
- b. Outreach activities- Village Health and Nutrition Days held every month to provide comprehensive primary care services at the people's doorstep
- c. Management of RTIs & STIs
- d. Safe Abortion Services

**II. Key issues**

***Systemic issues in States***

1. Poor governance & accountability
2. Lack of effective HR policies like timely recruitment, cadre reviews/promotion, rational deployment of trained and skilled manpower etc.
3. Shortfall of specialists & paramedical manpower
4. Absenteeism particularly among doctors
5. Underutilization and neglect of centres of excellence/ training centres
6. Lack of inter-departmental convergence and understanding.
7. Poor supply chain management and lack of sound procurement systems leading to high out-of-pocket expenses.

***Programmatic issues***

1. Lack of planning at state and district level for prioritizing resources in facility development
2. Operationalisation of facilities not linked with skill based training
3. Lack of an effective monitoring and supportive supervision structure
4. Poor skills among ANMs and nurses for providing skilled care



5. Inadequate Ante-natal Care and timely remedial action in high risk pregnancies e.g. under nutrition/ anaemia.
6. Weak IEC/BCC and household contact
7. Present strategy excludes adolescent girls (41 % maternal deaths are in 15 -24 years age group, 22% of the births are low birth weight).

### III. Way forward

#### i. ***Introduce differential planning***

- Long Term Investment Plan is prepared
- Investments follow commitment on outcomes
- Those who need the most get the most
- Needs are carefully assessed
- Gaps are worked out
- Additional resources are assured as per need

Under this strategy, target resources on identified “MCH Centres” in the high burden 264 districts accounting for about 70 % of maternal deaths:

- Set-Up layered MCH Centres i.e. Level-1, Level-2 & Level-3
- Ensure adherence to standardized protocols of service provision and service delivery
- Measure performance on outcomes.
- Strengthen Supportive Supervision.
- Provide supplementary logistics and linkages e.g. assured referral, transport, food etc.
- Make ANC a priority; ensure timely remedial action to tackle under nutrition / anaemia, referral tie up
- Incentivise stay at the facility for 48 hours e.g. free food, free drop back home

#### ***States to be held accountable for monitorable deliverables:***

- HR reforms e.g. expeditious and merit based recruitment rational deployment, stability of tenure, placement policy, timely promotions
  - Performance appraisal of service providers against benchmarks.
  - Performance based incentives for service providers
  - Results based financing for well performing facilities
  - Disincentives for poor performance e.g. non-renewal of contracts etc.
- ii. MoU with States – cost recovery in case of violation
  - iii. Focus on systems reforms in States e.g. uninterrupted supply chain of drugs and consumables etc.

- iv. Identification of wastages in the systems e.g. idle equipment, idle HR, mismatch of HR and equipment, infrastructure.
- v. Focus on vital missing links e.g. assured reliable, accessible, cost effective referral transport (most States do not have it yet).
- vi. Rigorous monitoring and review including field visits
- vii. States to be graded as A, B, C based on performance. "C" to be monitored most closely
- viii. Focus on quality improvements in education and skills training of ANMs/ Nurses for quality improvement.
- ix. Focus on client satisfaction e.g. feedback mechanisms, satisfaction index.
- x. Legal framework for reigning in private quacks e.g. RMPs/ GAMS doctors under Clinical Establishments Act.
- xi. Review JSY scheme to make it more targeted.

## **B. CHILD HEALTH**

### **I. Key strategies**

- a. Navjaat Shishu Suraksha Karyakram/ Basic newborn care and Resuscitation
- b. Infant and young child feeding
- c. Vitamin A supplementation and Iron and Folic Acid supplementation
- d. Early detection and appropriate management of Acute Respiratory Infections, Diarrhoea and other infections
- e. Integrated management of neonatal and childhood Illnesses (IMNCI) and Pre- Service IMNCI
- f. Facility Based Integrated management of neonatal and childhood Illnesses(F-IMNCI)
- g. Home Based Care of Newborns
- h. Management of children with malnutrition
- i. School Health

### **II. Key issues**

- 1. The key challenge for strengthening neonatal care are:
  - Lack of skilled personnel
  - Lack of performance appraisal and accountability
  - Poor maintenance and handling of equipments in neonatal units
  - Lack of assured referral transport for sick newborn/ infants. Most States have no policy in place.

- Low community awareness / BCC on new born care for early recognition of sickness and care of newborn
  - Inadequate home visits for post natal care for counselling, early detection, and referral
  - Lack of supportive supervision of health care providers
2. Acute Diarrhoea and Pneumonia continue to contribute to 22% of under-5 mortality and thus require intensive focus.
  3. In 34% of under-5 deaths, malnutrition is one of the main contributory factors. Nutrition is currently not addressed to the desired extent.
  4. Gaps in child health strategy –
    - Presently health needs of children above 6 – 12 years of age and 12 -18 years not fully met.
    - Small budgetary provision under school health programme.
    - Out of school children are not targeted

### **III. Way forward**

- i. New born care to be brought centre stage
- ii. State's thrust on institution delivery must encompass newborn care
- iii. Scale up IMNCI, NSSK with emphasis on quality
- iv. Introduce mechanisms to ensure upgraded skills are put to use
- v. Incentivise performance of service providers based on survival of newborns (on certification by community)
- vi. Focus on continuum of services viz. from adolescent girls to ANCs to newborn care and onwards
- vii. Seamless service from home to facility and back under a clearly articulated policy on free transport of sick newborn
- viii. Strengthening of home based newborn care by additionally involving ASHAs

## **C. IMMUNISATION**

### **I. Key strategies**

- a. Alternate vaccine delivery
- b. Cold chain strengthening
- c. Capacity building
- d. Ensuring vaccine logistics
- e. Monitoring of immunisation sessions
- f. Surveillance and management of Acute Events following Immunisation (AEFI)

## **II. Key issues**

1. Full immunization coverage is still only 62% as per coverage evaluation survey (CES), 2009 conducted by UNICEF
2. Absence of a legal framework to assure quality on the part of private service providers.
3. Maintenance of cold chain varies from state to state resulting in wastages and quality concerns.
4. Skill sets of cold chain handlers and vaccinators are below par.
5. Gaps in vaccine supply affect coverage and also lead to higher cost of procurement.
6. Lack of special strategy for difficult areas that become inaccessible for certain parts of the year.
7. Supportive supervision including quality checks is weak on account of non adherence to monitoring tools by states.
8. Information Education and Communication (IEC) for routine immunization is weak.
9. Cost consideration versus new vaccines dilemma e.g. current Routine Immunization vaccine costs Rs. 35 per child; Hib would cost Rs. 300

## **III. Way forward**

- i. Calibrate immunization activity as per need e.g. Intensive activity in low coverage areas; encourage area specific strategies.
- ii. Encourage more vaccine manufacturers for uninterrupted supplies.
- iii. Focus on quality training of service providers; strengthen IEC
- iv. Augment investment in maintenance of cold chain to tackle wastages
- v. Legal framework for private provider under "Clinical Establishment Act".
- vi. Rigorous monitoring and review of states with special adherence to Adverse Event Following Immunization (AEFI) and quality check.

## **D. FAMILY PLANNING**

### **I. Key strategies**

- a. Sterilization services
- b. 'Quality Assurance Committees' (QACs) in states and districts to ensure quality of services
- c. Increasing Male Participation In Planned Parenthood, including 'No Scalpel Vasectomy' (NSV):
- d. Promotion of IUD-380-A as a long-term and short-term spacing method:

- e. Operationalising 'Fixed Day Static' (FDS) services
- f. Promotion of emergency contraceptive pills
- g. Promotion of Post Partum Family Planning
- h. Strengthening contraceptive logistics

## II. Key issues

1. 49% of the increase in projected population in India will be contributed by the six major states of North India (UP, Bihar, MP, Rajasthan, Chhattisgarh and Jharkhand)
  - These states have TFR more than 3.
  - Unmet need for both spacing and limiting methods of contraception is very high in Uttar Pradesh (33.8) and Bihar (37.2)
  - Contraceptive prevalence rate is very low in UP (26.7), Bihar (28.4).
2. Contraceptive prevalence rate (for any modern contraceptive) India average is 46.2%
3. Non availability of trained service providers at peripheral health facility to provide regular quality FP services.
4. Lack of motivation of the staff to provide Family planning services.
5. Less focus on Post partum family planning services.
6. Unavailability of sufficient supply of contraceptives at the peripheral facilities.
7. Early marriage and teenage pregnancy

## III. Way forward

### ***Need to do the following***

- Improve access to FP services
- Improve quality of FP services
- Diversify contraceptive choices
- Make FP an integral part of MCH strategy
- Use FP as a powerful poverty reduction strategy
- Enhance awareness, dispel fears/ disinformation
- Promote Intersectoral Convergence
- Appreciate FP as a health, development and rights issue.

### **Specific activities**

- i. Strong political will and advocacy at the *highest levels*, e.g. Chief Ministers, parliamentarians, religious leaders and opinion leaders, for achieving population stabilization.
- ii. Fixed day static services at all facilities round the year by ensuring availability of trained service provider (Minilap, NSV, IUCD).

- iii. Revitalising Postpartum Family Planning services for all institutional deliveries.
- iv. Community Based Distribution of Contraceptives (Condoms, OCPs, EC Pills) through ASHAs and at VHNDs.
- v. Increasing basket of choices in contraceptives e.g. injectables, male contraceptives (RISUG).
- vi. Train more MBBS doctors in Minilap to augment service providers pool – focus on States with high unmet need.
- vii. Involve AYUSH doctors in FP initiative – incentivise them.
- viii. Integrate FP training into pre service education for doctors including AYUSH, ANMs, GNM and pharmacists.
- ix. Decentralising procurement of contraceptives to ensure regular, adequate and need based supply.
- x. Strengthening monitoring and providing performance based incentives
- xi. Private sector involvement for increasing provider base e.g. voucher & electronic transfer of incentive money; re-evaluating their incentive structure.
- xii. Give NGOs family planning as an important mandate.
- xiii. Renewed emphasis on IEC/BCC for generating demand for FP.
- xiv. Involving ICTCs for educating and counselling adolescents on reproductive health and contraception.
- xv. Launch the Adolescent initiative – make reproductive and sexual health, and pre-marriage and contraception counselling important components.
- xvi. Make FP progress an important conditionality for NRHM releases (e.g. upto 10%).
- xvii. Constitute a National Steering Group under HFM with HRD, WCD, RD, PR and YA as members for effective convergence; and State Steering Committees under CMs
- xviii. Sensitization meetings for CMs/ Health Secys/ NRHM MDs/ Directorate officers/ doctors/ ANMs/ pharmacists/ male workers/ nurses/ ASHAs/ VHSCs
- xix. Ensure State/ district/ block level FP officers are in place in all States
- xx. Intensify monitoring and review at the national level
- xxi. Increasingly use FP experts for advocacy= articles, interviews etc
- xxii. Articulate the economic case for FP and increase allocations
- xxiii. For 12th Plan, get FP included in Education, WCD, RD, PR, YA policies and plans

## **E. ADOLESCENT HEALTH**

### **I. Key strategies**

- a. Reorganizing the existing public health system in order to meet the service needs of adolescents.
  - Provision of adolescent-friendly health services in established institutions

- Provision of strategic information, accessibility to services and enabling & adolescent-friendly environment
- b. Strategic directions:
  - Incorporate adolescent issues in all RCH training programmes and all RCH materials developed for communication and behaviour change
  - Undertake special initiatives (e.g. Teen clinics) to reorganize services at PHCs on dedicated days and timings for adolescents
- c. Linkages with MoWCD, MHRD, NACP and NRHM interventions

## **II. Key issues**

1. Low priority at the state level to ARSH as compared to Maternal and Child Health programmes.
2. The adolescents health needs are not highlighted since disaggregated data is not generated in HMIS. The data available does not focus at ARSH related issues.
3. In many states the funds allocated for the ARSH component remain unspent/under spent.
4. Lack of understanding and systematic evidence of the situation and needs of adolescents.
5. Need for skill upgradation of the service providers to address issues regarding life skills and sexual and reproductive health including contraception with unmarried adolescents as well.
6. Need for strengthening the distribution network for IFA tablets for adolescents.
7. Need for strong referral linkage between out-reach services with the adolescents at the community and the health facility.
8. Need for convergence in programmes to reach out to adolescents within MoHFW and with other ministries.
9. Need for standardisation of AEP programmes and implementation in all schools including private schools

## **III. Way forward**

- i. A co-ordination cell/ new unit needs to be established at the Ministry of Health and Family Welfare with requisite experts in adolescent health to ensure integration of approach and implementation of ARSH, School Health and AEP programmes. This cell would also be responsible for the coordination with adolescent health programmes from other ministries.
- ii. Disaggregated data on health needs of adolescent population to be ensured in HMIS.
- iii. Further trainings for the service providers at all levels and orientation of State and District Programme managers.

- iv. Reorient adolescent health services to include a strong component of community based adolescent friendly health services (AFHS) and strengthen referrals.
- v. IEC activities are needed to provide young people with the information and skills to make the right decisions about health related behaviour including use of services. Multi media campaign for anaemia, menstrual hygiene and other related issues along with the action at the local community level.
- vi. A strategy is needed for peer groups as mobilisers since adolescents predominantly depend on their peers for guidance and the use of media comes only second to the peer groups.
- vii. Establishment of linkages with different groups, NGOs and institutions in communities for support and collaboration. A significant effort is needed to partner with private sector to move the agenda forward.
- viii. Operationalisation of dedicated clinics exclusively for adolescent clients and improving the quality of clinical care and strengthening of referral linkages. The quality of clinical care for common health problems of adolescents needs to be strengthened.
- ix. A need for focus on psychosocial concerns to act as entry point for engaging the adolescents in addressing the risk factors.
- x. Operationalisation of MIS system at the facility levels whereby the data for adolescents are disaggregated by age and sex, maintained in separate registers, and used for monthly report preparation and submission.
- xi. Adolescent issues and concerns should be incorporated at the undergraduate level and at the PG level especially in the Paediatrics, Obs & Gynae and community medicine.
- xii. A system of on-going monitoring and supportive supervision for the various cadres of service providers and refresher trainings based on the needs identified.



**VISION, MISSION, OBJECTIVES AND FUNCTIONS OF THE DEPARTMENT OF HEALTH & FAMILY WELFARE**

**Vision:**

To achieve acceptable standards of Good Health amongst general population of the country by the end of 12<sup>th</sup> Five Year Plan.

**Mission:**

1. Ensuring availability of quality healthcare on equitable, accessible and affordable basis across regions and communities with special focus on under-served population and marginalized groups.
2. Establishing comprehensive primary healthcare delivery system and well functioning linkages with secondary and tertiary care health delivery system.
3. Reducing Infant Mortality rate to 28 per 1000 live births and Maternal Mortality Ratio to 1 per 1000 live births by 2012.
4. Reducing the incidence of communicable diseases and putting in place a strategy to reduce the burden of non-communicable diseases.
5. Focusing on population stabilization in the country.
6. Developing the training capacity for providing human resources for health (medical, paramedical and managerial) with adequate skill mix at all levels.
7. Regulating health service delivery and promote rational use of pharmaceuticals in the country.

**Objectives:**

- (1) Improving access to primary health care services for all sections of society.
- (2) Improving Maternal and Child health.
- (3) Ensuring a reduction in the growth rate of population with a view to achieve population stabilization.
- (4) Developing human resources for health to achieve health goals.
- (5) Reducing overall disease burden of the society.
- (6) Strengthening Secondary and Tertiary health care.

**Functions:**

- 1) Policy formulation regarding issue relating to health and family welfare sectors.
- 2) Management of hospitals and other health institutions of Department of Health and Family Welfare.
- 3) Extending support to states for strengthening their health care system.
- 4) Reducing the burden of Communicable and Non-Communicable diseases.
- 5) Focus on development of human resources through appropriate medical and public health education.
- 6) Provide enabling regulatory framework for matters in Concurrent List of the Constitution. viz. medical, nursing, paramedical education, pharmaceuticals, etc.

## IDENTIFYING MCH CENTRES FOR ENHANCED INPUT AND INTENSIVE TRAINING

### The Background:

The experience of JSY has shown that in enabling environment women from all strata of society are willing to come to the health facilities for child-birth. The challenge is now to ensure that the expectation with which they come- a safe and comfortable delivery- is met. Further, for the investment in JSY to lead to reductions in neonatal and maternal mortality rates, the health system must have the capacity to manage the complications of delivery effectively.

To achieve such quality care, the RCH-NRHM programmes have been trying four major strategies:

- a) Strengthen the sub centres: by provision of skilled birth attendant training to ANMs and providing good infrastructure at the sub centres.
- b) Make PHCs into 24-hour PHCs – equipped with a team of at least three nurses and two doctors and linked to an assured referral transport system – which can manage all complications except those requiring surgery and blood transfusion.
- c) Provide a network of facilities which can provide emergency obstetric care including C-sections and blood transfusions.
- d) Provide adequate skills and infrastructure for the management of newborns in these facilities.

### The Need to Prioritise Facilities

Looking back at the development over the last five years, such facility development has often been fragmented and sub-critical to provide quality care. This often wastes a lot of resources without getting the health outcomes that we need. Thus in a district of over 300 sub centres only about 30 may be doing deliveries. Many of the other sub centres could be so near a PHC or higher facility that women prefer to go there- a rational choice. A few sub centres could be in places so difficult geographically that even to come to the sub centre after labour pains start could be difficult, and it would be easier for the ANM to go the home. Thus instead of investing equally in all the 300 sub centres if the district was to prioritise training of ANMs and building up of the infrastructure in these few sub centres, it could achieve quality care in all sub centre level delivery. However we would find that over a 100 ANMs would have been trained and many buildings built, but these 10 to 30 sub centres which are actually performing may still have major gaps. Such gaps could be closed within just one year, if planning is done.

Similarly in PHCs and additional PHCs and CHCs also we should prioritise for upgradation:

- a) Those PHCs which are managing significant case loads
- b) Those PHCs where home deliveries persist due to lack of an accessible PHC and therefore women are unable to exercise their choice.

The NRHM commitment was to make every PHC and CHC into a 24-hour facility for provision of comprehensive care by the year 2010. But the crisis in human resources needed has made it difficult to provide the nurses and doctors needed to reach this goal. Also in more developed districts due to improved roads and communication, health seeking behaviour starts preferring better equipped and functional facilities and it may no longer be necessary to develop so many facilities. For these reasons as an interim measure, we must in a focussed way develop a network of those facilities which could provide universal coverage and where we could concentrate our human and physical resources so as to achieve quality standards in MCH care within one or two years.

This principle has been understood and implemented for comprehensive emergency obstetric care where to prevent fragmentation of the limited specialists available, the recommendation has been to concentrate on developing a limited selection of facilities as FRUs, such that every primary care facility is within one hours back-up linkage of a FRU.

### **Operational guidelines for Maternal and Newborn Health and the understanding of MCH facilities:**

The Operational Guidelines for Maternal and Newborn Health, issued in June 2010, clearly specify these principles and defines the package of services and the level of clinical care and the standards of quality that would be available at each of these three levels:

- a) Level III: to be equated with comprehensive emergency obstetric care and sick newborn unit care- also referred to as the FRU
- b) Level II: to be equated with basic emergency obstetric care and equivalent newborn stabilisation care- similar to the 24-hour PHC concept.
- c) Level I: a standard of care which is less than the ideal, but what is pragmatic and possible to achieve in a sub centre or in a PHC with human resources less than what has been prescribed for level –II.

Taken together this is what has been described as MCH facilities.

### **The High- Focus District Strategy:**

To prioritise and direct resources in an even more focussed way, these MCH facilities are being first identified in a list of districts that have been identified as high focus districts. These 264 districts represent less than 35% of the nation's population but even when

applying the average state IMR and MMR, would account for about 50% of infant deaths and 60% of maternal deaths. If we adjust for these districts being lower than the state average, they could account for as much as 60% of child deaths and over 75% of maternal deaths. Further by focussing on these districts we also are shifting resources to those districts where facility development has been slower and where there are huge social or geographic constraints. Most of these districts would have lower internal capacity for improvement and would require infusion not only of additional resources but also of trainers, management support and supervisory staff to achieve these results in a short time.

### **Action Plans for MCH facilities in High Focus Districts:**

In a major coordinated effort by the states with support from technical support agencies, these MCH facilities have been identified in most of the 264 poor performing districts. This is given in the next page.

Once this is done the following immediate steps are to be taken as the action plan:

- a. Estimate the human resources gap that needs to be closed to meet the standards of care for that level, compute the total number of skilled providers needed and prioritise their recruitment and deployment.
- b. Estimate the skills gap in those already providing services, and prioritise their training- SBA training, training for newborn care, training for basic and for comprehensive emergency obstetric care, short term courses for specialist skills, training for safe abortion, for provision of both limiting and spacing methods of contraception etc. With careful prioritisation we could within a year or two ensure that all service provision within these districts is by appropriately trained and certified staff. Since internal capacity for training is likely to be limited, such training would often have to be provided in some state or national training sites or nationally recruited trainers would have to be deployed in these districts, if are to achieve such time-lines.
- c. Estimate the gaps in infrastructure in these designated MCH facilities and prioritise resources to close these gaps.
- d. Strengthen the logistics in these districts so that every facility has the drugs and equipment that it needs.
- e. Strengthen home based care – SBA home delivery where institutional delivery is not possible and home based care for newborns by ASHAs for every delivery. Even for institutional deliveries, after the first 48 hours, the ASHA trained in HBNC would have to be, in almost every state, the main strategy of reaching community level care to the newborn.
- f. Ensure that the services delivered includes the entire RCH package- ante-natal and post natal care, safe abortion services, male and female sterilisation services, IUD

and other spacing methods, adolescent clinics, RTI?STI management etc and not only care at delivery.

- g. Build in public-private partnerships to close gaps in service provision by the public sector. This is particularly urgent for private sector facilities which are being accessed by the poor – for lack of any alternative, for emergency care – often being referred from the public facility in the last hour. All such private facilities should be under a partnership such that the poor could avail of cashless health care at their moment of greatest need.
- h. Build in a supervisory support structure that would ensure that the skills imparted are practiced as also ensures that all the gaps identified as regards of quality of care with reference to the standards specified in the operational guidelines are also closed.
- i. Finally, externally assess and certify these facilities as MCH facilities which have achieved quality standards of care- consistent with the promises that JSY implies when it incentivises women to come to facilities for deliveries. Publicly declare this certification as a service guarantee and build in a system where any denial of quality care after these standards have met is addressed by a grievance redressal mechanism.

### **The larger picture:**

The understanding is that if we so prioritise at each level, we would have a rational plan for facility development that corresponds to peoples health seeking pattern, and also addresses areas where physical access to a facility is a problem and most important also attends to quality of care issues. The general principles of this approach are to define the package of services along with their quality standards, then identify and prioritise facilities for delivery of these services such that there would be universal access to the care, then build in community linkages and finally aggregate all this into technically and administratively competent district and state plans. Thus potentially this approach offers a way of taking forwards facility development from MCH services to ever expanding areas of health care provision- towards the goal of universal access to comprehensive health care.

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